Memorandum

Date MAY 25 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Review of Medicare Credit Balances--Independence Blue Cross of Philadelphia, Pennsylvania (A-03-92-00004)

To William Toby, Jr.
Acting Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on May 26, 1993, of our final audit report. A copy is attached.

The report summarizes the results of our review of Medicare outpatient accounts receivable with credit balances at 11 hospitals serviced by Independence Blue Cross (IBC) of Philadelphia, Pennsylvania. Our primary objective was to determine if hospitals were reviewing Medicare accounts receivable with credit balances and refunding identified Medicare overpayments to IBC. A secondary objective was to evaluate IBC's monitoring of hospitals' procedures for refunding Medicare overpayments.

Our review showed that hospitals were not routinely reviewing Medicare outpatient credit balance accounts to identify Medicare overpayments that should be refunded to IBC. As a result, 8 of the 11 hospitals received and retained Medicare overpayments estimated at $232,890. We estimate that the 40 hospitals received and retained Medicare overpayments of $1,249,179. Our review also showed that while IBC's auditors gave limited coverage of credit balances during their field reviews, they did not review hospitals' policies and procedures for establishing credit balances.

The Health Care Financing Administration (HCFA) has recognized the need for improvements at both hospitals and intermediaries. Effective June 30, 1992, hospitals were required to report all Medicare credit balances quarterly to their intermediary. Using these quarterly reports, intermediaries will be able to identify and track all Medicare overpayments and ensure the overpayments are recovered from the hospitals. We believe that HCFA's reporting requirements should lead to significant improvements in the recovery of Medicare overpayments, but only if hospitals fully implement them and intermediaries closely monitor the implementation.

We have issued individual audit reports to the 11 hospitals included in this review. As appropriate, we have recommended procedural improvements aimed at ensuring that the hospitals review Medicare credit balances timely and refund all Medicare overpayments to IBC. We have also recommended that 8 of the 11 hospitals refund to IBC $232,890 in Medicare overpayments that we identified during our field reviews.

In this report, we recommended that IBC expand its audit coverage of Medicare credit balances; and ensure that hospitals comply with HCFA's reporting requirements and identify and repay all Medicare overpayments. We also recommended that IBC require 8 of the 11 hospitals refund Medicare overpayments totaling $232,890, and monitor the reporting of overpayments by the other hospitals that it serves.

In a response to our draft report, dated June 4, 1992, IBC described the actions taken in response to our audit recommendations. We believe these actions, coupled with HCFA's credit balance reporting requirements, will improve IBC's controls over Medicare overpayments to hospitals. In this regard, we noted that the hospitals serviced by IBC reported $2 million of Medicare overpayments as of the December 31, 1992 reporting period.

For further information, contact:

Thomas J. Robertson
Regional Inspector General for
Audit Services, Region III
(215) 596-6744

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE CREDIT BALANCES INDEPENDENCE BLUE CROSS OF PHILADELPHIA, PENNSYLVANIA

MAY 1993 A-03-92-00004

DEPARTMENT OF HEALTH & HUMAN SERVICES

REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19104

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P.O. BOX 13716, MAIL STOP 9
PHILADELPHIA,
PENNSYLVANIA 19101

MAY 26 1993

Our Reference: Common Identification Number A-03-92-00004

Mr. Robert A. McKeown
Senior Vice President
Medicare Operations &
Provider Services
1901 Market Street
Philadelphia, Pennsylvania 19104

Dear Mr. McKeown:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report titled REVIEW OF MEDICARE OUTPATIENT CREDIT BALANCES, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PENNSYLVANIA. Your attention is invited to the audit findings and recommendations contained in the report.

Final determination as to actions to be taken on all matters will be made by the HHS official named below. The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time. A copy of this report has been provided to the Blue Cross Association.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See 45 CFR Part 5)

To facilitate identification, please refer to the referenced common identification number in all correspondence relating to this report.

Sincerely yours,

Thomas J. Robertson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

Mr. Dennis Carrol
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration
Region III

SUMMARY

We have completed our review of outpatient Medicare accounts receivable with credit balances at 11 of the 40 hospitals serviced by Independence Blue Cross (IBC) of Philadelphia, Pennsylvania. Our primary objective was to determine if hospitals were reviewing outpatient Medicare accounts receivable with credit balances (hereafter referred to as Medicare credit balances), and refunding identified Medicare overpayments to IBC. Our secondary objective was to evaluate IBC's monitoring of hospitals' procedures for refunding Medicare overpayments.

Our review showed that most hospitals were not routinely reviewing Medicare credit balance accounts to identify overpayments that should be refunded to IBC. As a result, 8 of the 11 hospitals received and retained Medicare overpayments of $232,890. Projecting our results to all hospitals serviced by IBC, we estimate that the 40 hospitals received and retained Medicare overpayments of $1,249,179 (Appendix A).

Hospitals retained Medicare overpayments an average of 279 days from the establishment of the credit balances to the close of our reviews.

There appears to be no valid reason why hospitals did not routinely review all of their outpatient Medicare credit balances to identify Medicare overpayments. The number of these accounts--only 3 of the 11 hospitals had over 100 of them--indicates that it is feasible to review them. The amount of Medicare overpayments involved, estimated at over $1.2 million--indicates that such reviews are warranted.

We have issued audit reports to the 11 hospitals included in our review. As appropriate, we have recommended procedural improvements aimed at ensuring that outpatient Medicare credit balances are reviewed timely and that all Medicare overpayments are refunded to IBC. We have also recommended that the eight hospitals refund to IBC $232,890 in Medicare overpayments that we identified during our field reviews. In this report, we summarize the results of our review at the 11 hospitals.

The Health Care Financing Administration (HCFA) has also recognized the need for improvements. Effective June 30, 1992, hospitals are required to report all Medicare credit balances quarterly to their intermediary. Using these quarterly reports, intermediaries will be able to ensure that all Medicare overpayments are recovered from the hospitals. We believe that HCFA's reporting requirements should lead to significant improvements in the recovery of Medicare overpayments, but only if hospitals fully implement them and intermediaries closely monitor the implementation.

We are, therefore, recommending that IBC expand its audit coverage to ensure hospitals' compliance with HCFA's reporting requirements and the identification and repayment of all Medicare overpayments. We are also recommending that IBC require the 8 hospitals identified in our review to refund Medicare overpayments totaling $232,890, and monitor the reporting of overpayments by the other hospitals that it serves.

On June 4, 1992, IBC responded to a draft of this audit report. The IBC agreed to seek recovery of the identified overpayments at the eight hospitals, but expressed concern over one of our recommendations included in the draft report which involved special reviews at the hospitals not included in our audit.

We have reviewed IBC's response and have made certain changes to this report, including modifying the recommendation dealing with the special reviews. We believe the actions taken by IBC, coupled with HCFA's credit balance reporting requirements, will improve IBC's controls over Medicare overpayments to hospitals. In this regard, we noted that the hospitals serviced by IBC reported over $2 million of Medicare overpayments as of HCFA's December 31, 1992 reporting period.

We have summarized IBC's response, along with our comments relative to the response, at the end of this report. We have also included the response in its entirety as Appendix C.

CONTENTS

INTRODUCTION

BACKGROUND

The Health Insurance for the Aged and Disabled program (Medicare), Title XVIII of the Social Security Act, provides for a hospital insurance program (Part A) and a related medical insurance program (Part B) to eligible beneficiaries. The Health Care Financing Administration (HCFA) administers the Medicare program at the Federal level. Under an agreement with the Secretary of the Department of Health and Human Services (HHS), Blue Cross Association (BCA) participates in the administration of the Medicare Part A program. The Independence Blue Cross (IBC), under a sub-contract with BCA, is responsible for the receipt, review, audit, and payment of Medicare Part A claims submitted by the providers it services.

The IBC services 40 hospitals in the Philadelphia, Pennsylvania area and reimburses these hospitals for both inpatient and outpatient services provided to Medicare beneficiaries. One of IBC's responsibilities is to identify and collect Medicare overpayments made to these 40 hospitals.

A credit balance in a Medicare account receivable occurs when a hospital records a higher reimbursement than the amount charged for a specific Medicare beneficiary. A credit balance does not necessarily mean that a Medicare overpayment has occurred.

Hospitals must review each outpatient Medicare credit balance to identify an overpayment for refund to the intermediary.

Some Medicare credit balances result from accounting errors and errors in calculating coinsurance amounts. In these instances, a Medicare overpayment is unlikely to have occurred. Other Medicare credit balances result, either in whole or in part, from duplicate payments made by an intermediary, from payments made by an intermediary and a primary insurer for the same service provided to the same patient, and from payments made for anticipated services that were not actually provided. In these cases, a Medicare overpayment exists and should be refunded to the intermediary. Since IBC is responsible for identifying overpayments, it also shares responsibility with hospitals for ensuring that Medicare credit balances caused by Medicare overpayments are refunded to the Medicare program.

SCOPE OF AUDIT

Our audit was made in accordance with generally accepted Government auditing standards. Our primary objective was to determine if hospitals serviced by IBC were reviewing

outpatient Medicare credit balances to identify Medicare overpayments and refunding the overpayments to IBC. A secondary objective was to determine if IBC was evaluating hospital procedures for reviewing outpatient Medicare credit balances during its provider audits.

We selected 11 of the 40 hospitals serviced by IBC (Appendix A). Eight of the hospitals were randomly selected so that we could statistically project the results of our review to all hospitals serviced by IBC. Three of the hospitals were specifically selected for review.

The hospitals generally categorized credit balances first by the type of service provided, that is, outpatient and inpatient service, and then by the reimbursement sources, that is, Medicare, Medicaid and commercial insurance. We limited our review to outpatient Medicare credit balances. We reviewed the credit balances to determine if Medicare overpayments had occurred that were not refunded to IBC. We did this through use of such records as credit balance runs, patient files, remittance advices, hospital payment histories and IBC's payment histories.

Three of the 11 hospitals selected had on their accounting records more than 100 outpatient Medicare credit balances of over $100. At each of these 3 hospitals we randomly selected 100 outpatient Medicare credit balances for review, and projected the results of our statistical sample using standard Office of Audit Services (OAS) software programs to the universe of outpatient Medicare credit balances which exceeded $100. At the 8 hospitals where the universe of Medicare outpatient credit balances was less than 100 accounts, we reviewed all Medicare credit balances.

Using the same OAS software programs, we projected the results of our reviews at the 8 randomly selected hospitals to 37 of the 40 hospitals serviced by IBC. We added the results of our reviews at the 3 hospitals specifically selected to the projected results to arrive at a total overpayment amount for the 40 hospitals serviced by IBC.

Our review was limited to outpatient Medicare credit balances recorded on the hospitals' accounting records. We did not review the hospitals' policies and procedures for establishing and writing-off credit balances, for identifying primary insurers, or for processing Medicare claims to the intermediary. We also did not review either the hospitals' or IBC's compliance with HCFA's reporting requirements for Medicare credit balances. These requirements became effective after the close of our reviews.

We have issued final audit reports to the 11 hospitals included in this review. This audit report summarizes our findings at

the 11 hospitals and includes information on IBC's review of hospital policies and procedures on outpatient Medicare credit balances.

Other than the issues discussed in the FINDINGS AND RECOMMENDATIONS section of this report, we found no instances of noncompliance with applicable laws and regulations. With respect to those items not tested, nothing came to our attention to cause us to believe that the untested items were not in compliance with applicable laws and regulations. Our field work was performed at the 11 hospitals and at IBC from September 1990 to December 1991.

FINDINGS AND RECOMMENDATIONS

MOST HOSPITALS DID NOT REFUND MEDICARE OVERPAYMENTS TO IBC

Based on the results of our review at 11 hospitals, we estimate that the 40 hospitals serviced by IBC kept $1,249,179 in Medicare overpayments. The main reason why these overpayments were not refunded to IBC was that the hospitals did not routinely review Medicare credit balances to identify overpayments for refund.

The IBC services 40 Medicare participating hospitals. We reviewed 11 of them to determine if they were reviewing outpatient Medicare credit balances and refunding Medicare overpayments to IBC. Our summary results are shown below.

SUMMARY RESULTS OF REVIEW
Outpatient Medicare Credit Balances

Hospitals	Number	Overpayments	
		Number	Amount
Einstein *	100	50	$161,868
Temple	100	35	44,373
North Penn *	100	25	9,500
Magee Rehab	50	14	8,059
S. Chester *	28	7	3,422
Warminister *	42	9	2,441
Delaware V. *	12	6	2,053
Lawndale *	18	3	1,174
St. Joseph's	10	0	0
St. Agnes *	4	0	0
Eagleville *	0	0	0
Total	464	149	$232,890

The above chart identifies (*) the eight hospitals that we randomly selected. It also identifies the 10 hospitals that

had outpatient Medicare credit balances on their accounting records at the time of our review. We reviewed 464 of the credit balances at the 10 hospitals and determined that 149 (32 percent) of the credit balances at 8 hospitals were caused by Medicare overpayments. As shown above, the 8 hospitals had overpayments totaling $232,890 that were not refunded to Medicare.

We projected the results of our reviews at the 8 randomly selected hospitals to 37 Medicare participating hospitals serviced by IBC. The projected overpayment to the 37 hospitals is $1,176,916. The overpayment to the 3 hospitals specifically selected for review is estimated at $72,263. The total Medicare overpayment to the 40 hospitals serviced by IBC, therefore, is estimated at $1,249,179.

The overpayments were recorded on the hospitals' accounting records an average of 279 days as of the close of our reviews (Appendix B). The reason that they remained on the accounting records for so long is that the hospitals had not established procedures to routinely review outpatient Medicare credit balances so that Medicare overpayments could be identified and refunded to IBC.

Causes of Medicare Overpayments

Had the hospitals reviewed their Medicare credit balances timely, they would have likely identified the 149 Medicare overpayments. They would have also likely determined that the causes for the overpayments were generally traceable to their billing practices which resulted in duplicate billings, retaining Medicare payments for services reimbursed by another primary insurer and billing Medicare for services not performed. We found that 99 percent of the overpayments were caused by one of the three billing practices as shown below.

CAUSES OF OVERPAYMENTS

- **$733,356 in duplicate billing**
- **$359,976 for services reimbursed by a primary insurer**
- **$148,668 for services not performed**
- **$7,179 for various IBC errors**

Duplicate Billing of Services

Seventy-five outpatient Medicare credit balances were caused by hospitals submitting more than one bill to IBC for the same service rendered to the same beneficiary. The IBC failed to detect the multiple bills and reimbursed the hospitals for them. We reviewed records at IBC and the hospitals to determine why the multiple bills escaped IBC detection. We were unable to determine exactly how 10 of the 75 multiple bills apparently escaped detection by IBC's edit checks. We were, however, able to determine that:

- 45 duplicate payments resulted from hospitals submitting multiple bills using different health insurance claim numbers, revenue codes, charges or dates of service for the same service to the same beneficiary. Since the bills were not exact duplicates, IBC did not detect them and prevent the overpayments.

- 8 duplicate payments resulted from hospitals submitting a separate bill for an individual service and including the same service on a cumulative bill which covered all services received by a Medicare beneficiary during a given period of time such as a week or month. Since the bills were not exact duplicates, IBC did not detect them, and prevent the overpayments.

- 6 duplicate payments resulted from hospitals billing for outpatient services that were included as part of an inpatient claim. Medicare regulations require that any outpatient service performed within 72 hours (24 hours prior to February 1991) of a hospital admission be included as part of the inpatient service. Since the bills were not exact duplicates, IBC did not detect them and prevent the overpayments.

- 6 duplicate payments resulted from hospitals submitting exact duplicate bills. These duplicate bills should have been, but were not, detected by IBC's edit checks. The IBC should determine if there is a flaw in its edit checks that requires correction.

Based on the results of our review, we estimate that the 40 hospitals serviced by IBC received Medicare overpayments totaling $733,356 as a result of submitting multiple bills for the same service provided to the same beneficiary.

Services Reimbursed by Another Insurer

Fifty outpatient Medicare credit balances were caused by hospitals billing Medicare and a primary commercial insurer for the same service, receiving payment from both, and keeping both payments. The provisions of the Medicare Secondary Payor (MSP) program state that Medicare will not reimburse for services covered by another insurer. The hospitals established credit balances for the excess reimbursements but did not review them further to identify Medicare overpayments.

Based on the results of our review, we estimate that the 40 hospitals serviced by IBC received Medicare overpayments totaling $359,976 by not refunding the Medicare payments to IBC after receiving payment from primary commercial insurers.

Services Not Performed

Twenty-two outpatient Medicare credit balances were caused by hospitals billing IBC for services that were not performed. Usually this occurred when hospitals anticipated that a service would be performed but was not because of some unforseen circumstance. Subsequent to submitting the bills to IBC, the hospitals became aware that the services were not performed and canceled the charges. Since the Medicare reimbursements exceeded the hospitals' adjusted charges, the hospitals established outpatient Medicare credit balances but did not review them to identify Medicare overpayments.

Based on the results of our review, we estimate that hospitals received Medicare overpayments totaling $148,668 for submitting claims for services not performed.

Miscellaneous

Two outpatient Medicare credit balances were caused by IBC errors dealing with the number of services billed versus paid and the ineligibility of a patient for Medicare. The hospitals established credit balances on their accounting records for the excess reimbursements but did not review them to identify the Medicare overpayments.

Based on the results of our review, we estimate that hospitals received Medicare overpayments totaling $7,179 because of miscellaneous reimbursement errors made by IBC.

IBC Audits of Hospital Outpatient Medicare Credit Balances

Our primary objective in this review was to determine if hospitals were reviewing outpatient Medicare credit balances and refunding identified Medicare overpayments to IBC. We believe that hospitals are primarily responsible for this process. We also believe that intermediaries such as IBC share in this responsibility at least to the point of reviewing hospitals' policies and procedures on Medicare credit balances during routine hospital audits.

Our review showed that IBC did provide some audit coverage to outpatient Medicare credit balances. We believe, however, that IBC should expand its audit program to include a review of hospitals' policies and procedures for reviewing Medicare credit balances.

According to IBC's hospital audit program, auditors were to obtain a current listing of Medicare credit balances, take a representative sample, and obtain an explanation for each credit balance sampled. The results were to be turned over to IBC management which was to forward them to the MSP section.

While IBC's audit program included a review of selected Medicare credit balances, it did not specifically include a review of the hospitals' policies and procedures for reviewing Medicare credit balances and refunding Medicare overpayments. Without such a review, it may not be possible for IBC's auditors to detect weaknesses in these policies and procedures.

Conclusions and Recommendations

Based on our review of 11 of the 40 hospitals serviced by IBC, we believe that the majority of the hospitals did not review timely outpatient Medicare credit balances to identify overpayments for refund to IBC. As a result, the hospitals kept Medicare overpayments estimated at over $1.2 million rather than refund them to IBC.

We have issued individual audit reports to the 11 hospitals included in this review. As warranted, we have made appropriate procedural recommendations aimed at ensuring timely refunds of Medicare overpayments. We have also recommended that 8 hospitals refund $232,890 to IBC. Most of the hospitals that responded to our reports agreed with our findings and recommendations, and agreed to take the necessary corrective action. The principal responsibility for detecting and repaying overpayments lies with the hospitals, however, IBC should expand its audit program to ensure that hospitals

policies and procedures for reviewing Medicare credit balances are adequate.

The HCFA recognized the need for procedural improvements at both hospitals and intermediaries. As a result, HCFA has established quarterly reporting requirements for Medicare credit balances. Effective June 30, 1992, each hospital is required to submit to its intermediary a quarterly listing of all Medicare credit balances involving Medicare overpayments. Hospitals can submit refunds directly to IBC which must reconcile them quarterly. The implementation of HCFA's quarterly reporting requirements should, in our opinion, lead to significant improvements in the recovery of Medicare overpayments, but only if hospitals fully implement them and intermediaries closely monitor the implementation.

We, therefore, recommend that IBC:

1. Expand its hospital audit coverage to include an evaluation of the hospitals' compliance with HCFA reporting requirements. Credit balances should be reviewed to determine if the hospitals identified all Medicare overpayments and made timely repayment.

2. Require the 8 hospitals identified in our review to refund Medicare overpayments totaling $232,890.

3. Monitor the reporting of Medicare credit balances at the 29 other hospitals not included in our review to ensure that the outpatient Medicare overpayments refunded by the hospitals approximate $1 million ($1. 2 million minus $232,890).

IBC Response and Office of Audit Services Comments

In its response (Appendix C), IBC stated that it is supportive of our efforts to review Medicare credit balances. The IBC agreed with our recommendation to seek recovery of the $232,890 identified in this report, and stated that action is underway to do so. The IBC also provided additional information concerning its audits of Medicare credit balances, and stated that it had reviewed the reasons for the duplicate payments and had taken the appropriate corrective action.

The IBC expressed concern that our draft recommendation calling for special reviews at the 29 hospitals not included in our review was based on a statistical sample with an extremely high standard error. The IBC suggested that implementation of the HCFA reporting requirements by the hospitals, and its auditing of the hospitals' reporting efforts would achieve the intent of the recommendation.

We have reviewed IBC's response and have made certain changes to this report. We recognize that our statistical sample, although statistically valid, had a high standard error. We have modified the recommendation dealing with special reviews of the 29 hospitals (if the Medicare overpayments reported by all 40 hospitals totaled significantly less than our estimate of $1.2 million). The strengthening of IBC's audit procedures as stated in its response (that is, auditing hospitals' compliance with HCFA reporting requirements) should negate the need for the special reviews.

We believe that the actions taken by IBC in response to our report, coupled with HCFA's reporting requirements will improve controls over Medicare overpayments. In this regard, we noted that hospitals serviced by IBC reported over $2 million of Medicare overpayments as of the December 31, 1992 reporting period.

INDEPENDENCE BLUE CROSS
STATISTICAL PROJECTION OF FINDINGS

PROJECTION OF FINDINGS TO UNIVERSE OF 40 HOSPITALS SERVICED BY IBC

HOSPITAL REVIEWED	NUMBER OF CR.BAL.	TOTAL CR.BAL REVIEWED	NUMBER OF FINDINGS	AMOUNT OF FINDINGS	POINT ESTIMATE	DUPLICATE PAYMENTS	MEDICARE SECONDARY PAYOR	SERVICES NOT PERFORMED	MEDICARE REIMB. ERRORS
ALBERT EINSTEIN MEDICAL CENTER *	1845	100	50	$12,536	$231,283	$135,142	$66,539	$29,602	$0
NORTH PENN HOSPITAL *	174	100	25	$8,101	$14,096	$11,159	$2,457	$480	$0
SOUTHERN CHESTER COUNTY MEDICAL CENTER *	28	28	7	$3,422	$3,422	$463	$2,044	$56	$859
DELAWARE VALLEY MEDICAL CENTER *	12	12	6	$2,053	$2,053	$874	$309	$188	$682
LAWNDALE COMMUNITY HOSPITAL *	18	18	3	$1,174	$1,174	$248	$926	$0	$0
WARMINSTER GENERAL HOSPITAL *	42	42	9	$2,441	$2,441	$979	$1,462	$0	$0
SAINT AGNES MEDICAL CENTER *	4	4	0	$0	$0	$0	$0	$0	$0
EAGLEVILLE HOSPITAL *	0	0	0	$0	$0	$0	$0	$0	$0
SUBTOTAL	2123	304	100	$29,727	$254,469	$148,865	$73,737	$30,326	$1,541
PERCENTAGE OF TOTAL FINDINGS					100%	58.49%	28.98%	11.92%	0.61%
ALLOCATION OF PROJECTION TO 37 HOSPITALS					$1,176,916	$688,379	$341,070	$140,288	$7,179
TEMPLE UNIVERSITY HOSPITAL	365	100	36	$17,590	$64,204	$43,910	$12,646	$7,648	$0
MAGEE REHABILITATION HOSPITAL	50	50	14	$8,059	$8,059	$1,067	$6,260	$732	$0
SAINT JOSEPH'S HOSPITAL	10	10	0	$0	$0	$0	$0	$0	$0
TOTAL	2548	464	150	$55,376	$1,249,179	$733,356	$359,976	$148,668	$1,179
PERCENTAGE OF EACH FINDING TO TOTAL					100%	58.7%	28.8%	11.9%	0.6%

STANDARD ERROR OF PROJECTION: $939,265

* - RANDOMLY SELECTED FROM 40 HOSPITALS SERVICED BY IBC

INDEPENDENCE BLUE CROSS
AGING OF CREDIT BALANCE OVERPAYMENTS

HOSPITAL	AVG. DAY OF CR. BAL. AGING	61-200 DAYS	201-400 DAYS	401-600 DAYS	>601 DAYS	TOTAL NUMBER OF OVERPAYMENTS
ALBERT EINSTEIN MEDICAL CENTER *	638	5	13	9	23	50
NORTH PENN HOSPITAL *	386	7	10	3	5	25
SOUTHERN CHESTER COUNTY MEDICAL CENTER *	266	4	2	1		7
DELAWARE VALLEY MEDICAL CENTER *	155	4	2			6
LAWNDALE COMMUNITY HOSPITAL *	258	1	2			3
WARMINSTER GENERAL HOSPITAL *	298	1	7	1		9
SAINT AGNES MEDICAL CENTER *	0					0
EAGLEVILLE HOSPITAL *	0					0
TEMPLE UNIVERSITY HOSPITAL	336	6	18	7	4	35
MAGEE REHABILITATION HOSPITAL	735	0	2	3	9	14
SAINT JOSEPH'S HOSPITAL	0					0
	279	28	56	24	41	149

* - RANDOMLY SELECTED FROM 40 HOSPITAL SERVICED BY IBC

Independence Blue Cross Medicare

1901 Market Street. Philadelphia. Pennsylvania 19103-1480

June 4, 1992

Mr. G. A. Rafalko
Regional Inspector General
for Audit Services
Department of Health and
Human Services
Region III
3535 Market Street
Philadelphia, PA 19104

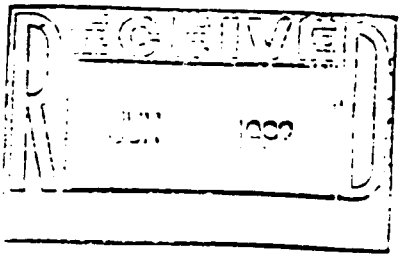
Re: A-03-92-00004

Dear Mr. Rafalko:

Thank you for the opportunity to comment on your April 23, 1992 draft report entitled "Review of Medicare Outpatient Credit Balances, Independence Blue Cross, Philadelphia, Pennsylvania."

As noted in your report, the primary objective of the Office of Inspector General (OIG) review was focused at 11 area hospitals to determine if hospitals were reviewing outpatient Medicare accounts receivable with credit balances and the secondary objective was to determine if IBC was evaluating hospital procedures for reviewing outpatient Medicare credit balances during its provider audits. Our comments will address the secondary objective and OIG's related conclusions and recommendations.

IBC is supportive of the OIG effort to review Medicare credit balances. IBC and HCFA-RO files, going back as far as 1988 and 1989, have identified the audit of credit balances as an audit initiative which goes beyond the audit mandates in field audits performed by fiscal intermediaries. A special audit initiative was proposed during that period, however, the effort was not funded by HCFA and, therefore, the project was not implemented.



Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report.

Regarding the OIG recommendations that IBC require hospitals to establish procedures to review outpatient Medicare credit balances timely, as well as refunding $232,889 identified in eight hospitals as Medicare overpayments, IBC concurs with these recommendations. IBC, under HCFA-RO direction, has collected the amount of the overpayment shown in the individual provider's report for 7 of the 11 hospitals. The remaining four are in the following categories: 1) IBC was directed not to collect the over-payment for two hospitals, as the matter would be handled by

the OIG - Office of Investigation; however, one has repaid the money to IBC through claims adjustments; 2) IBC has received HCFA direction on 5/19/92, to collect the overpayment - and recovery action is anticipated within 60 days; 3) no report issued to provider as amount of overpayment was zero. IBC has solicited at HCFA's direction, the hospitals' procedures for timely review of credit balances and the refunding of overpayments for all 11 providers. All hospitals have responded satisfactorily except three. One has told IBC orally that they intend to refute the OIG's report and, therefore, they have not responded; and two have not responded to our requests, one because the response is due by 6/25/92. IBC considers these recommendations satisfied unless they receive further direction from the HCFA-RO.

Our Medicare Claims department has reviewed the six exact duplicate bills mentioned in your report to determine if there is a systemic flaw within the edit checks. Two of the cases related to the claims payment system that was in place prior to the current one and, to comment further would not be relevant at this time. The remaining four are related to our present system, for which providers submitted two identical bills at the same time. This present bill processing system has been corrected to identify the above described situation. IBC considers this recommendation resolved.

The OIG projects their estimate of the outpatient credit balance overpayment to about $1.2 million for the 29 hospitals not reviewed. They also suggest that a special review of outpatient Medicare credit balances be performed. Notwithstanding our concerns with the OIG's projection of credit balance overpayments, IBC would support a separately funded credit balance audit initiative, which would go beyond the scope recommended in the report. IBC is available to discuss this with HCFA and the OIG should this project be pursued.

IBC has concerns with the projection of the overpayment for outpatient credit balances to approximately $1.2 million. A review of the OIG's workpaper supporting the projection discloses that 91% of the raw data used in the projection was from one hospital provider, while the remaining seven providers had nominal or zero overpayments. This has resulted in the OIG projections calculating a standard error of $939,265. If this is subtracted from the calculated

projection, it results in an amount less than the raw data overpayment ($254,469) ($1,176,916 -$939,265 = $237,651). It is our opinion that the above situation has developed from the inclusion of an atypical provider in the projection. If the provider which represents 91% of the raw data overpayment is eliminated, we estimate that the projected overpayment would be about $350,000. This would seem to be a more reasonable figure given the large standard error and the nominal impact for the seven randomly reviewed providers. At this point IBC is concerned that a review of the 29 unaudited providers may not be cost effective. A credit balance project initiated by HCFA last fiscal year has recovered a significant portion of the overpayments ($700,000), and the planned reinstatement of the project should resolve any open amounts. Additionally, the cost effectiveness of 29 additional reviews is in question, based on the OIG audit efforts at the 11 area hospitals, the cost of auditing 29 hospitals would be about $200,000. We request that the OIG reconsider their recommendation for the audit of 29 hospitals, as these results can be achieved in a more cost effective manner (i.e., the reinstatement of the HCFA credit balance recovery project and the efficient use of field auditor time to review the provider reporting efforts for the recovery projects when they perform their regularly scheduled provider audits).

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report.

In summary, IBC has provided the OIG with the following information: 1) clarification of the audit effort regarding credit balances; the audit effort satisfies or exceeds HCFA's audit expectations; 2) Provider procedures and overpayments have been identified and collections made where appropriate; 3) known exact duplicate situations have been eliminated; and 4) comments concerning the need to perform 29 additional audits to recover credit balance overpayments.

We believe the draft report should be revised to incorporate the clarification of information contained in this reply. Again we thank you for the opportunity to comment on the draft report and we are available to review with your staff any of the information contained in this letter.

Sincerely,

Robert A. McKeown
Senior Vice President,
Medicare Operations &
Provider Services

RAMcK:dc:760
cc: Diane C. Moskal,
Acting Associate Regional Administrator
Division of Medicare, Region III